

PM Form 3.14.3 TRBHA PRIOR AUTHORIZATION REQUEST FORM

INSTRUCTIONS

- A. This form is completed by the TRBHA staff prior to admission as follows:
- **For non-emergency admissions**, this form is completed prior to admission, 8:00 a.m. to 5:00 p.m. Monday through Friday.
 - **For emergency admissions**, this form is completed within 24 hours or the next business day of an admission made after 5:00 p.m. on Monday through Friday, on weekends or State holidays.
- B. The form is faxed to ADHS/BQME at **(602) 364-4749**. ADHS/BQME completes Section II of the form and returns the form to the TRBHA staff. This form must be accompanied with the following:
- ☐ Certification of Need for Acute Hospital/Inpatient, Sub-acute and RTC
 - ☐ Treatment plan/service plan

Section I (to be completed by TRBHA staff)

Client Name: _____ Date of Birth: / /

Client ID #: _____ TRBHA Name: _____

AHCCCS ID #: _____ TRBHA Staff: _____

Diagnosis *(Must be numeric value per ICD 9 criteria)*: _____

Proposed Placement: _____

Provider Name: _____ Provider ID #: _____

Date of Admission: _____ Length of Stay: _____

Requested Service Dates: From: / / To: / /

Service Code: _____

Type of Service Requested: ☐ Acute Hospital/Inpatient ☐ Sub-acute ☐ RTC

Program Type: ☐ GMH ☐ SMI ☐ Child/Adolescent ☐ Drug/Alcohol

TRBHA Staff Signature: _____ Date: / /

Section II (to be completed by ADHS/BQME)

Action: ☐ Approved ☐ Denied

If denied, explain (cite specific criteria not met): _____

Approved Length of Stay: _____ Approved Service Dates: _____

Authorization Number: _____

Authorized ADHS/BQME Signature: _____ Date: / /